Compassion and patient centred care

Anthony C T Stevenson, *MBBS, DRANZCOG, FACRRM, is a registrar specialising in rural and indigenous health, General Practice Education Australia Ltd, and a general practitioner, The Aboriginal and Islander Community Health Service Brisbane Ltd, Queensland.*

BACKGROUND The essence of medicine is a relationship based upon a concern for suffering. Western medicine, arising from a modernistic philosophy, has a tradition of paternalistic 'doctor centred' care. There are significant criticisms of this approach.
OBJECTIVE Drawing on postmodern perspectives, this article discusses the nature of patient centred care. Patient centred care requires a reconciliation of the patient's and doctor's agenda via attention to communication, power and patient autonomy. Patient centred care has been defined by six domains: the illness experience, the context, finding common ground, partnership, health promotion, and consultation limitations.
DISCUSSION Patients strongly desire patient centred care. It has been associated with improved patient and doctor satisfaction, greater compliance, fewer investigations, referrals and malpractice complaints, and no change in consultation time. Patient centred care exerts a positive influence on health outcomes and is especially applicable in general practice, providing an efficacious and compassionate response to suffering.

This paper is an edited version of a literature review, 'On patient centred care' accepted by the Royal Australian College of General Practitioners Training Program New South Wales in November 2001, for completion of a professional development project.

Patient
Latin **pati** — to suffer

1. one that suffers
2. a client for medical service

Care
Old English **Cearu** — lament
Greek **Gerys** — voice

1. to feel interest, concern, solicitude
2. responsibility for attention to safety and wellbeing[1]

Case history

Betty is 48 years old, with a history of hypertension, impaired glucose tolerance, obesity and panic attacks. You recall her history of diazepam dependence and your suspicion that she used to 'doctor shop'. Recently, she has repeatedly presented with chest pains; however, ECG, bloods and an exercise stress test have been normal. She speaks with a stutter and your heart sinks as you glance at the clock.

The essence of medicine is a relationship whose core attribute is a concern for suffering. The fundamental requirement of this relationship is communication: a patient's story and a physician's response.[2,3]

Western medicine has developed from the natural sciences, which gained ascendancy in Western societies in the modern period.[4,5] The biomedical basis of medicine can be viewed as a surrogate child of modernism – the monistic Western view of an objective and fixed reality.[4,6] Larivaara, Kiuttu and Taanila[6] describe doctors as 'culturally defined experts' who possess knowledge, skills and legislated rights which are inaccessible to patients. In this context, much authority rests with the physician which has engendered a tradition of paternalism. Within this 'doctor centred' relationship the physician acts as guardian; patients' values are assumed consistent with (or subservient to) those of the physician,

and patient autonomy is restricted to assent to treatment.[7] The goal of the doctor centred consultation is to make an 'objective' diagnosis – an approach characterised by the interruption of the patient's story and closed biomedical questioning.[6,7] Eighteen seconds is the average time that a patient is allowed to speak before being interrupted.[8]

Betty had chest pains over the weekend and had been to the emergency department again. She says the doctors asked lots of questions, they were quite abrupt and made her feel like she was wasting their time. They couldn't find anything serious, but said they would refer her for a 'radioactive scan'.

The doctor centred consultation remains the dominant paradigm in primary care,[7,9] yet, in 50% of consultations patients and doctors disagree on the presenting problem. Fifty-four percent of patient problems and 45% of patient concerns remain undisclosed (including 50% of psychosocial problems). A significant proportion of patients are dissatisfied with the information provided to them.[8] It would appear that physicians are often ineffective in the fundamental clinical function of communication and the community increasingly criticises this approach.[2,8]

A key assumption of the 'biomedical model' is that illness (ie. seeking help) coincides with pathophysiological disease[9,10] which can be defined objectively. However, a postmodern perspective asserts that observers interact with their subjects and challenges the concept of 'objective truth'.[3,6,10] Illness is defined by the subjective experience of suffering which can only be determined by reference to the individual whose behaviour may bear little relation to disease.[10,11] A pathophysiological diagnosis is not a realistic goal in a significant proportion of presentations.[9,10] Mead and Bower[10] point out: 'That in order to understand illness and alleviate suffering, medicine must first understand the personal meaning of illness for the patient...and that a combined biological, psychological and social perspective is necessary to account for the range of problems presented'.

Patients are now active 'partakers', voicing rights to full information and minimum standards.[2] These stances reflect a recognition by the community that the physician's values are not necessarily the same as, nor superior to, those of the patient, and that an assumption of beneficient responsibility by the physician cannot be maintained without relegation of patient autonomy.

Patient centred care is a renaissance of the general practice tradition of personal attention.[3] Larivaara et al[6] describe a paradigm in which 'the doctor and the patient are equal knowers, who by communicating together, create shared expertise'. The doctor must integrate the patient's and their own agenda. The aim is to understand the ill patient and to diagnose any disease.[9] One comprehensive model defines six domains of the patient centred consultation:[10,12–14]

Explore the illness experience and for disease – the agenda

Betty is upset and confused. She is petrified of dying of a heart attack and is anxious about a radioactive injection. She denies having chest pain today, but with much stuttering she requests a prescription for diazepam to help her sleep.

The essence of the patient centred method is to try to enter the patient's world and see the illness through their eyes.[9] The patient must reveal their experiences, feelings, fears and expectations[15] (which are not necessarily verbalised or explicit). The key skills are to listen and facilitate 'story telling'. Empathy, receptivity to cues and use of open ended questions should be combined with nonjudgmental validation of patients' emotions.[6,9]

Understand the patient as a person – the context

During the next visit Betty 'breaks down', telling a story of domestic violence and being left a single mum. Her 13 year old son weighs 90 kg and is missing school, her 15 year old son was involved in a liquor store burglary and Betty reported him to the Police to 'get him away from the bad crowd'.
Her 17 year old unemployed daughter is morbidly obese and intermittently uses 'speed'. Her eldest daughter is a heroin 'junkie', who arrived from Sydney several weeks ago. Betty is desperate to help her.
You realise that her daughter's arrival seemed to coincide with the onset of her chest pains.

An exploration of a patient's life setting is vital – their family, attitude toward illness, employment and their socioeconomic factors. Patients' past experiences may alter reactions to the current illness. Culturally determined beliefs about illness may be profoundly different to those of the physician (remembering biomedical training is itself a sociocultural system).[16,17] A picture of context may be the key to understanding a presentation or may alter the management imperatives.

Management – finding common ground

With this in mind, you explain heart disease, chest pain and anxiety, and discuss a stress thallium scan. She resists your attempts to prescribe antidepressants for her generalised anxiety disorder, (she thinks they're addictive), however, she readily accepts your referral to the community mental health team.

The doctor and patient need to establish priorities, goals, and roles, including diagnostic and management advice.[6]

If there is discordance between the doctor's and patient's priorities, common ground should be sought, although agreement may not always be attained,[9] eg. the poorly controlled diabetic who does not acknowledge any problem. The success of this domain is closely related to how effectively the participants can communicate.

Enhance the patient–doctor relationship

Over time you establish a good rapport with Betty. She admits to obtaining diazepam from another doctor. She says that she hasn't used it in over 12 months, but likes to have it at home 'just in case'. Her daughter has been using it to cope with withdrawal symptoms. You raise the matter of her stutter and Betty reveals a past of childhood sexual abuse. As a young teenager she stole diazepam to try to stay asleep when 'he' came at night.

An egalitarian relationship is based upon a sustained partnership[2] with attention to the issues of power and control being paramount,[10] calling for respect for patient autonomy with legitimisation of their knowledge and experience. This 'therapeutic alliance' has value in and of itself,[10,18] affecting health through 'a biology of self confidence'.[19] Patient participation reduces fear and engenders a sense of control. However, full transfer of decision making power is not necessarily beneficial and egalitarianism should not mean total abdication of power.[8] Physicians can support patients' autonomy while providing direction and exercising discretion.[6]

Health promotion — prevention of suffering

You spend a consultation discussing sleep hygiene, exercise, the family diet and Betty's risk of diabetes. You refer her and her son to the community dietician.

A duty of the physician is to anticipate disease and identify emerging problems.[9] Subtle trends or risks to a patient's well-being may only be recognised when a more intimate knowledge of that person is possessed.

Limitations – the doctor as a person

Your success with Betty has been built upon a series of consultations and by her preparedness to open up. This in turn is reliant upon your respect for her and your willingness to address her fears. While acknowledging your inherent bias regarding drug dependence and your frustration with the diagnostic dilemmas, you have constructed a mutually satisfying relationship on which to base future care. You understand the constraints of general practice and have appropriately involved a multidisciplinary team.

There are both personal and environmental limitations to what can be achieved by any person within time and resource constraints. Physicians are individuals with inherent subjectivity whose personal qualities are bound to influence the relationship.[3,6,20] Mead and Bower[10] conceptualise 'two person medicine' in which the doctor and patient influence each other and cannot be considered separately. Physicians require self awareness of personal qualities and reactions.

These six domains are an academic dissection of this postmodern philosophy, which serve to construct a framework by which the concept can be understood. But what evidence is there that this approach is desirable, practical and efficacious?

Patients strongly desire a friendly and open approach, to be listened to, be understood, to be offered clear explanations and discussions, partnership, and health promotion.[13] More information is obtained using a patient centred approach with communication being the single most important determinant of patient and doctor satisfaction.[6] Roter et al[7] observed five patterns of consultation:

- narrow biomedical
- expanded biomedical
- biopsychosocial
- psychosocial, and
- consumerist.

The average length of consultations were not significantly different among the styles with the biopsychosocial pattern being associated with the shortest average duration. Patient satisfaction was significantly higher for interactions involving attention to psychosocial health than for other consultations. Narrow biomedical consultations were self rated by physicians as least satisfying and less likely to achieve their goals, and were also associated with a significant discordance between physicians' and patients' ratings of the patient's emotional health. In other trials, a patient centred approach resulted in:

- no change in consultation time
- improved patient satisfaction
- higher physician satisfaction, and
- fewer malpractice complaints.[19,21]

In a comprehensive review regarding health outcomes, Stewart[8] concluded that there is level 1 and level 2 evidence that 'effective communication exerted a positive influence...not only on the emotional health of the patient, but also on symptom resolution, functional and physiological states (blood pressure and blood sugar level) and pain control'. She also found that patient centred consultations are associated with greater compliance with treatment[19] and fewer investigations and referrals.[9] It appears that physician explanation is the crucial stage of the visit, and it is the patient's assessment of the quality of the interaction which is the best predictor of improved outcomes.

Several studies associate improved communication with improved HbA_{1c} in diabetes mellitus and decreased blood pressure in hypertension.[8] However, two studies assessing patient centred care and diabetes[21,22] found no significant change in HbA_{1c}. In one study,[21] the intervention

group actually had higher body mass indices and triglyceride levels at one year. Although communication and wellbeing were significantly improved without loss of glycaemic control, failure to negotiate behavioural change could result in higher cardiovascular disease risk. This highlights the dual nature of patient centred care in which patients' and physicians' differing priorities require skilled negotiation for an ideal outcome.[9]

Patient centred care is applicable in every speciality, especially in general practice. McWhinney[3] notes that: 'The commitment of the general practitioner is to the person...General practice defines itself in terms of relationships, not in terms of diseases or technologies'. He aptly describes the relationship as a covenant. In a technology driven, biomedical culture, it is easy to lose sight of this covenant and its fundamental requirement for an appreciation of our patients' lives and suffering. Patient centred care effectively reconciles medical intervention with a sense of compassion. Gray[23] states there are evils and good that are universally human; I assert that a compassionate response to suffering is a universal good. It is from this quality that physicians derive their profession, for fearless healthy individuals do not present for our opinions.

Conflict of interest: none declared

Acknowledgments

I wish to thank Dr Hilton Koppe for his encouragement and mentorship on this topic, and Charles, Maria and Linda for 'moulding the graduate'.

References

1. Webster's Third New International Dictionary. Springfield Mass USA: Merian Webster Inc, 1993.
2. Toop L. Primary care: core values: patient centred primary care. Br Med J 1998; 316:1882–1883.
3. McWhinney I R. Primary care: core values: Core values in a changing world. Br Med J 1998; 316:1807–1809.
4. Hobsbawm E. Sorcerers and apprentices – the natural sciences. Age of Extremes The Short Twentieth Century 1914–1991 London: Michael Joseph, Penguin Books, 1994; 522–525.
5. Davies P. Science and religion in a changing world. God and the New Physics. London: Penguin Books, 1990; 1–3.
6. Larivaara P, Kiuttu J, Taanila A. The patient centred interview: the key to biopsychosocial diagnosis and treatment. Scand J Prim Health Care 2001; 19:8–13.
7. Roter D L, Stewart M, Putnam S M, Lipkin M, Stiles W, Inui T S. Communication patterns of primary care physicians. JAMA 1997; 277:350–356.
8. Stewart M. Effective physician patient communication and health outcomes: a review. CMAJ 1995; 152:1423–1433.
9. Levenstein J H, McCracken E C, McWhinney I R, Stewart M A, Brown J B. The patient centred clinical method. A model for the doctor patient interaction in family medicine. Fam Pract 1986; 3:24–30.
10. Mead N, Bower P. Patient centredness: a conceptual framework and review of the empirical literature. Soc Sci Med 2000; 51:1087–110.
11. Loblay R L, Stewart G, Bertouch J, et al. Chronic fatigue syndrome clinical practice guidelines – 2002. Med J Aust 2002; 176(Suppl):S23.
12. Stewart M. Towards a global definition of patient centred care: the patient should be the judge of patient centred care. Br Med J 2001; 322:444–445.
13. Little P, Everitt H, Williamson I, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. Br Med J 2001; 322:1–7.
14. Stewart M, Brown J B, Weston W W, McWhinney I R, McWilliam C L, Freeman T R. Patient centred medicine transforming the clinical method. Thousand Oaks CA: Sage Publications, 1995; 21–30.
15. Brown J, Stewart M, McCracken E, McWhinney IR, Levenstein J. The patient centred clinical method. Definition and application. Fam Pract 1986; 3:75–80.
16. Carillo J E, Green A R, Betancourt J R. Cross cultural primary care: a patient based approach. Ann Int Med 1999; 130:829–834.
17. Scrimgeour D, Beaton N. Discussion Paper The role of the general practitioner in Aboriginal Health. Royal Australian College of General Practitioners Training Program New South Wales Aboriginal Health Training Module, 2000.
18. Matthews D A, Suchman A L, Branch W T. Making 'connexions': enhancing the therapeutic potential of patient clinician relationships. Ann Int Med 1993; 118:973–977.
19. Stewart M, Brown J B, Donner A, McWhinney I R, Oates J, Weston W W, Jordan J. The impact of patient centred care on outcomes. J Fam Pract 2000; 49:796–804.
20. Thomas K B. General practice consultations: is there any point in being positive? Br Med J 1987; 294:1200–1202.
21. Kinmonth A L, Woodcock A, Griffin S, Spiegal N, Campbell M J. Randomised controlled trial of patient centred care of diabetes in general practice: impact on current wellbeing and future disease risk. Br Med J 1998; 317:1202–1208.
22. Pill R, Stott N C H, Rollnick SR, Rees M. A randomized controlled trial of an intervention designed to improve the care given in general practice to type 2 diabetic patients: patient outcomes and professional ability to change behaviour. Fam Pract 1998; 15:229–235.
23. Gray J. The United States and the utopia of global capitalism. False dawn: The delusions of global capitalism. London: Granta Books, 1998; 130.

AFP

Correspondence

Anthony Stevenson
The Aboriginal and Islander Community Health Service Brisbane Ltd
10 Hubert St
Woolloongabba
Brisbane, Qld 4102
Email: noisypitta@ozemail.com.au